

# HEALTH BENEFIT COMPARISON

Effective January 1, 2009



This comparison is only a summary of benefits. Benefits will be administered as described in each plan's subscriber agreement or plan document. For further detail, refer to those documents or call Wellmark Blue Cross Blue Shield. (Health plan options differ by bargaining unit/status.)

	Wellmark BC/BS Deductible 3 Plus	Wellmark BC/BS Program 3 Plus	Wellmark BC/BS Iowa Select		Wellmark BC/BS Managed Care Plans
			In Network (Select Provider)	Out-of-Network (Non-Select Provider)	Blue Access Blue Advantage
<b>General Conditions of Coverage</b>					
<b>Benefits Available from Non-Participating Providers</b>	Normal plan benefits.	Normal plan benefits.	Normal plan benefits for select providers.	Normal plan benefits for non-select providers.	None, unless prescribed, referred and approved by a participating physician, or in an emergency medical condition, or with prior authorization from the plan (when required).
<b>Coinsurance Percentage</b>	20%. All services	20%. All services	10%	20%	Varies; see below.
<b>Deductible Single/Family</b>	\$300/\$400 applies to <u>all</u> services. Any portion of deductible satisfied in last three months of year will be credited for following year as well.	\$300/\$400, inpatient services only.	\$250/\$500. Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of select provider.	\$250/\$500. Applies to both inpatient and outpatient services.	None.
<b>Dependent Child Age Limit</b>	<ul style="list-style-type: none"> <li>- Unmarried children under age 25 and reside in the State of Iowa.</li> <li>- Unmarried children that are full-time students in an accredited institution of postsecondary education regardless of age.</li> <li>- Totally and permanently disabled, physically or mentally, children regardless of age. The disability must have existed before the child turned age 25.</li> </ul>				
<b>Medical Out-of-Pocket Limit Single/Family</b>	\$600/\$800. All deductibles, coinsurance, and copayments go toward out-of-pocket limit.	\$600/\$800. All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit. Emergency Room copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit. Emergency Room copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$750/\$1500. All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.
<b>Lifetime Benefit Maximum</b>	None.	None.	None.	None.	None.
<b>New Employee Preexisting Condition Waiting Period</b>	11 months.	11 months.	11 months.		None.

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<b>Your Payment Responsibilities</b>					
<b>Medical Services</b>					
<b>Accidents</b>	0%, after deductible for all treatment within 72 hours of accident.	0%, no deductible for all treatment within 72 hours of accident.	10%, deductible waived in office setting.	20%, after deductible. Emergency care covered at in-network level.	\$10 copayment office visit. \$50 copayment for ER, waived if admitted. .
<b>Allergy Treatment</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10.00 copayment per visit.
<b>Ambulance</b>	20%, after deductible.	20%, no deductible.	20%, after deductible.	20%, after deductible.	0% if medically necessary/emergency medical services.
<b>Blood, Blood Plasma, Blood Serum</b>	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
<b>Chiropractor</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10.00 copay if approved provider.
<b>Dental Accident Care</b>	0%, after deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.	0%, no deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.	10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.	20%, after deductible. Limited to services provided within 72 hours of accident.	20% if authorized by Wellmark BCBS for injury to sound natural teeth. Services must be within 6 months of injury and injury must have occurred while member enrolled in plan.
<b>Durable Medical Equipment</b>	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	20% if prescribed by a participating provider and obtained from a supplier authorized by Wellmark BCBS.
<b>Emergency Room (ER Care)</b>	0%, after deductible. Also see section on "Accidents".	0%, no deductible. Also see section on "Accidents".	\$50.00 copayment; waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.		\$50.00 copayment; waived if admitted.
<b>Eyeglasses</b>	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Hearing Aids</b>	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Hemodialysis</b>	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	0% if obtained in a center authorized by Wellmark BCBS.
<b>Home Health Care</b>	20%, after deductible. Pre-certification required.	20%, no deductible. Pre-certification required.	10%, after deductible. Pre-certification required.	20%, after deductible. Pre-certification required.	0% if authorized by Wellmark BCBS.
<b>Hospice Care</b>	20%, after deductible. Pre-certification required.	20%, no deductible. Pre-certification required.	10%, after deductible. Pre-certification required.	20%, after deductible Pre-certification required.	0% if medically authorized by Wellmark BCBS.
<b>Infertility Services</b>	\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.	\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.	\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.		Not covered
<b>Inpatient Physician Services</b>	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.

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<b>Inpatient Room &amp; Board</b>	20%, after deductible. No limit on medical surgical days. Pre-certification of admission required by member.	20% after inpatient services deductible. No limit on medical surgical days. Pre-certification of admission required by member.	10%, after deductible. No limit on medical surgical days. Pre-certification of admission required by select provider.	20%, after deductible. No limit on medical surgical days. Pre-certification of admission required by member.	0% if authorized. Semi-private basis, unless medically necessary to use a private room. May require prior approval.
<b>Inpatient Supplies, Drugs, Medicines, etc.</b>	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
<b>Inpatient Surgery</b>	20%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	10%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	0% if authorized.
<b>Inpatient Tests, ICU, Operating Room, Specialized Care, etc.</b>	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
<b>Large Case Management</b>	Alternative care set up on a case by case basis by plan.	Alternative care set up on a case by case basis by plan.	Alternative care set up on a case by case basis by plan.	Alternative care set up on a case by case basis by plan.	Alternative care set up on a case-by-case basis.
<b>Maternity</b>	20%, after deductible.	20%, no deductible for pre- and post-natal office visits.	10%, deductible waived in office setting for pre- and post-natal visits.	20% after deductible.	0% for delivery. \$10.00 copayment for initial visit; remaining pre- and post-natal visits paid in full.
<b>Mental Health/Substance Abuse</b>					
<b><u>Mental Health</u> Inpatient Hospital Room &amp; Board</b>	20%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
<b><u>Mental Health</u> Inpatient Physician Care</b>	20%, after deductible. Maximum of 60 days per member per calendar year.	20%. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
<b><u>Mental Health</u> Outpatient</b>	20%, after deductible.	20%.	10%, deductible waived in office setting	20%, after deductible.	\$10.00 copayment per visit. Maximum of 52 visits per member per calendar year.
<b><u>Substance Abuse</u> Inpatient Hospital Room &amp; Board</b>	20%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	20%. Maximum of 30 days per member per calendar year.
<b><u>Substance Abuse</u> Inpatient Physician Care</b>	20%, after deductible. Maximum of 60 days per member per calendar year.	20%. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
<b><u>Substance Abuse</u> Outpatient</b>	20%, after deductible.	20%.	10%, deductible waived in office setting.	20%, after deductible.	\$20.00 copayment per visit. Maximum of 30 visits per member per calendar year.
<b>Nursing Facility Providing Skilled Care</b>	20%, after deductible, unlimited days. Pre-certification required.	20% after deductible. Unlimited days. Pre-certification required.	10% after deductible. Unlimited days. Pre-certification required.	20% after deductible. Unlimited days. Pre-certification	0%. Maximum of 120 days per member per calendar year.

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<b>Occupational Therapy</b>	20%, after deductible. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	\$10.00 copayment per visit. Maximum 60 visits per member per year.
<b>Office Visit</b>	20%, after deductible.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket Limit.</b> 20% coinsurance, no deductible for other office services.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket Limit.</b> 10% coinsurance, deductible waived in office setting for other office services.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket Limit.</b> 20% coinsurance, after deductible, for other office services.	\$10.00 copayment per visit.
<b>Organ Transplants</b>	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart/lung, lung (single and double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow, and allogeneic bone marrow transplants 100% covered if authorized by Wellmark BCBS. No coverage if experimental or in a nonauthorized facility.
<b>Outpatient Chemotherapy</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit.
<b>Outpatient Surgery</b>	0%, after deductible. Required for certain procedures.	0%, no deductible. Required for certain procedures.	10%, after deductible. Required for certain procedures. Approval obtained by select provider.	20%, after deductible. Required for certain procedures.	0% if authorized.
<b>Outpatient Surgery Setting</b>	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Select provider obtains approval.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Participating physician will determine appropriate surgical setting.
<b>Physical Therapy</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10.00 copayment per visit. Maximum 60 visits per member per year.
<b>Preapproval of Inpatient Admissions</b>	Required.	Required.	Required.	Required.	Required.
<b>Prosthetic Appliances and Other Devices</b>	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	20% if authorized by participating physician and obtained from an authorized supplier.

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<b>Respiratory Therapy</b>	20%, after deductible payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Must be hospital-based billed or as a part of approved home health services.	\$10.00 copayment per visit. Maximum 60 visits per member per year.
<b>Routine Eye Exam</b>	Not covered.	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	\$10.00 copayment per visit. Limit of one exam per member per year.
<b>Routine Hearing Exam</b>	Not covered.	Not covered.	10%, deductible waived. Limit of one exam per member per year.	20%, deductible waived. Limit of one exam per member per year.	\$10.00 copayment per visit. Limit of one exam per member per year.
<b>Routine Physicals</b>	20%, after deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	20%, no deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limit of one physical per member per year..	20% after deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	\$10.00 copayment per visit, excluding travel, employment, or athletic related/required.
<b>Second Surgical Opinion</b>	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits when received from plan provider.
<b>Speech Therapy</b>	20%, after deductible payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	\$10.00 copayment per visit. Maximum 60 visits per member per year.
<b>TMJ</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	Not covered.
<b>Well Child Care</b>	20%, to 7 years. No deductible.	20%, to 7 years. No deductible.	10% to 7 years. Deductible waived in office setting.	20%, to 7 years. No deductible.	\$10.00 copayment per visit.
<b>X-Ray and Lab</b>	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20% after deductible.	0%
<b>PRESCRIPTION DRUGS</b>					
<b>Retail</b>					
<b>Quantity</b>	30-day supply	30-day supply per copay	30-day supply per copay	30-day supply per copay	30-day supply per copay
<b>Preferred Generic Drugs</b>	20%, after deductible.	\$5.00 copay for each prescription or refill	\$5.00 copay for each prescription or refill	\$5.00 copay for each prescription or refill	\$5.00 copay for each prescription or refill
<b>Preferred Brand Name Drugs</b>	20%, after deductible.	\$15.00 copay for each prescription or refill	\$15.00 copay for each prescription or refill	\$15.00 copay for each prescription or refill	\$15.00 copay for each prescription or refill
<b>Non-preferred Generic and Non-preferred Brand Name Drugs</b>	20%, after deductible.	\$30.00 copay for each prescription or refill	\$30.00 copay for each prescription or refill	\$30.00 copay for each prescription or refill	\$30.00 copay or 25%, whichever is greater, for each prescription or refill

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<b>Mail Order</b>					
Quantity	No mail order benefit available	90-day supply per copay	90-day supply per copay	No out-of-network coverage available	90-day supply per copay
Preferred Generic Drugs		\$10.00 copay for each prescription or refill	\$10.00 copay for each prescription or refill		\$10.00 copay for each prescription or refill
Preferred Brand Name Drugs		\$30.00 copay for each prescription or refill	\$30.00 copay for each prescription or refill		\$30.00 copay for each prescription or refill
Non-preferred Generic and Non-preferred Brand Name Drugs		\$60.00 copay for each prescription or refill	\$60.00 copay for each prescription or refill		\$60.00 copay for each prescription or refill
<b>Specialty Drugs</b>					
Quantity	30-day supply	30-day supply per copay	30-day supply per copay	30-day supply per copay	30-day supply per copay
Retail	20%, after deductible.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.
Mail Order	No mail order benefit available	No mail order benefit available	No mail order benefit available	No mail order benefit available	No mail order benefit available
<b>Prescription Drug Benefit – General Information</b>					
Pharmacy Out-of-Pocket Maximum	No separate out-of-pocket maximum.	Single <b>\$250</b> Family <b>\$500</b> <small>(This limit is separate from the medical out-of-pocket.)</small>	Single <b>\$250</b> Family <b>\$500</b> <small>(This limit is separate from the medical out-of-pocket.)</small>	No separate out-of-pocket maximum. Copayments do <b>NOT</b> apply to medical out-of-pocket maximum.	
Prescription Oral Contraceptives and Contraceptive Devices	Covered	Covered.	Covered.	Covered.	
Prescription Drug Coverage – Additional Information		If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay <b>and</b> any difference between the billed charge for the brand name drug and the billed charge for the generic.	If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay <b>and</b> any difference between the billed charge for the brand name drug and the billed charge for the generic.	Rx must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed.	

NOTE: The Wellmark Blue Cross and Blue Shield (BCBS) plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BCBS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the covered charge may be satisfied by BCBS's payment to the provider plus any amounts the provider agrees to waive under its contract with BCBS. Please see your benefits booklet for more information.